Appendix D Service Authorization (PP)

Last Updated: 04/20/2022

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INTRODUCTION

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

PURPOSE OF SERVICE AUTHORIZATION

The purpose service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, and established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

Currently, the Traditional Inpatient and Outpatient services requiring authorization are reviewed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO).

Magellan of Virginia is the Behavioral Health Services Administrator and perform service authorization for the following services:

- Inpatient Psychiatric Services, service type 0401;
- Freestanding Psychiatric Hospital Services, service type 0093;
- Outpatient Psychiatric Services, service type 0050; and
- Outpatient Substance Abuse Services 0051.

GENERAL INFORMATION REGARDING SERVICE AUTHORIZATION

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy

and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to physician level staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care programs, the Srv Auth entity will honor the Medicaid MCO service authorization if the member has been disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO.

Srv Auth decisions by the DMAS Srv Auth contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM (PP)

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor’s authorization for a period of not less than 90 days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the Srv Auth contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 60 day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period;
C. For CCC Plus Waiver Services, Cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the Srv Auth

Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The Srv Auth contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Communication

Provider manuals are located on the DMAS web portal and KEPRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Inpatient* tab.

The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

OVERVIEW

DMAS has contracted the services of a medical review organization (Service Authorization Contractor) to provide service authorization of all inpatient hospital admissions.

All admissions must be service authorized within 1 business day of the admission. A business day is defined as 12:00 am – 11:59 pm Monday – Friday with the exception of recognized holidays. The health care provider calling to initiate service authorization of the admission must provide the member's name; the identification number; the admitting physician's name; the primary care physician's name (if applicable); the admission diagnosis and ICD-CM diagnosis code(s); the medical indication for hospitalization; and the plan of care.

The Srv Auth Contractor, KEPRO, will apply McKesson InterQual® ISD-AC criteria to the medical information provided; a service authorization number will be assigned for admission

for medical/surgical services or for an initial length of stay for psychiatric inpatient services through November 30, 2013. KEPRO will not receive requests for Inpatient Psychiatric Services, service type 0401; Freestanding Psychiatric Hospital Services, service type 0093; Outpatient Psychiatric Services, service type 0050; and Outpatient Substance Abuse Services, service type 0051.

Magellan of Virginia is the Behavioral Health Services Administrator and performs service authorization for the following services:

Inpatient Psychiatric Services, service type 0401;

Freestanding Psychiatric Hospital Services, service type 0093;

Outpatient Psychiatric Services, service type 0050; and

Outpatient Substance Abuse Services service type 0051.

Please refer to DMAS web site at www.dmas.virginia.gov for Magellan of Virginia contact information or contact the DMAS Helpline at 1-800-552-8627 or 804-786-6273.

SUBMITTING SRV AUTH REQUESTS FOR INPATIENT ACUTE HOSPITAL ADMISSIONS (EFFECTIVE SEPTEMBER 1, 2015)

Requests for Inpatient Acute Hospital admissions will only be accepted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo). The only inpatient service type requiring Atrezzo portal submission is Inpatient Acute Hospital (service type 0400). For detailed information refer to the June 15, 2015 DMAS memo.

How to Register for Atrezzo Connect

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to http://dmas.kepro.com, and click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS,

please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, the *General* tab and then *Atrezzo Connect - Registration*.

Submitting Requests via Atrezzo Connect

Once registered, inpatient acute hospital providers will use the Atrezzo portal for submitting all requests. This includes admissions, change requests, transfers, responding to pend requests, and other applicable transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, an Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, the *General* tab and then *Atrezzo Connect – Portal User Guide*.

For inpatient acute hospital requests completion of the inpatient questionnaire is now required. All providers will attest electronically that information submitted to KEPRO is within the member's documented record. If the responses match the criterion for the specific service or diagnosis, the case will bypass a reviewer and be approved, and automatically batch for transmission to MMIS. If the responses do not match the specific criterion, the case will go to a reviewer's queue which will follow the normal review process.

Providers can also contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com for additional assistance with registering and any questions regarding submitting srv auth requests.

**Note to providers: The information submitted to KEPRO for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the member's needs. Any person who knowingly submits information to KEPRO containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

SERVICE AUTHORIZATION REQUESTS

Effective April 1, 2012, certain services previously reviewed by DMAS' Medical Support Unit (MSU) will now be reviewed by Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor. KEPRO will begin accepting requests, regardless of the dates of service, on April 1, 2012.

KEPRO will allow retroactive reviews for service requests submitted through June 30, 2012 only for the procedure codes attached to the March 9, 2012 DMAS Memo titled "Services Currently Reviewed by DMAS' Medical Support Unit Moving to KEPRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"***. Effective July 1, 2012 KEPRO will not authorize requests retroactively for these procedure codes, regardless of the dates of service.** The only instance KEPRO will approve services retroactively on and after July 1, 2012 is when the provider demonstrates retroactive Medicaid eligibility determination for members.

See the "Exhibits" section at the end of this appendix for instructions on how to access DMAS' Procedure Fee Files to determine if services need to be authorized.

KEPRO will accept requests through direct data entry (DDE), fax, telephone or US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to http://dmas.kepro.com. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

Provider Registration is Required to use Atrezzo Connect.

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to http://dmas.kepro.com , and click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, the *General* tab and then *Atrezzo Connect - Registration*.

Faxing Requests to KePRO

Providers must use specific fax forms when requesting services. If the fax form is not accompanied by the request, KEPRO will reject the request back to the provider and the provider must resubmit the entire request with the fax form. Appropriate fax forms to use are the DMAS 351 *(Procedures/Devices Service Authorization Request Form)* and DMAS 363 *(Outpatient Service Authorization Request Form.* Providers may fax requests to 1-877-652-9329. Forms are available on KEPRO's website at http://dmas.kepro.com. Providers may click on the "*Forms*" tab to view a listing of all KEPRO fax forms, labeled by form number and service type. Fax forms list the service types and names of the specific services applicable to each form.

Timeliness of Submission by Providers, Effective July 1, 2012 and Forward

All requests for services must be submitted prior to services being rendered. KEPRO will allow a grace period through June 30, 2012 for providers to submit requests for services already rendered. **This grace period only applies to the procedure codes attached to the DMAS Memo dated March 9, 2012 and titled "**Services Currently Reviewed by DMAS' Medical Support Unit Moving to KEPRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012*"**. Effective July 1, 2012 there will be no retroactive authorization.** This means that if the provider is untimely submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Processing Requests at KEPRO

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KEPRO notifies the member and the provider in writing of the status of the request through the Medicaid Management Information System (MMIS) letter generation process. For organ transplants, an additional letter will be faxed to the provider.

Providers who have received an approved service authorization prior to April 1, 2012 from DMAS' Medical Support Unit will receive an additional letter generated by the MMIS. This letter is to ensure that all approved service authorizations are accessible to KEPRO. These letters will be mailed between March 9, 2012 and April 1, 2012.

If there is insufficient medical necessity information to make a final determination, KePRO will pend the request back to the provider requesting additional information. If the information is not received within the time frame requested by KEPRO, the request will automatically be sent to a physician for a final determination with all information that has been submitted. In the absence of clinical information, the request will be submitted to the supervisor for review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

Specific Information for Service Type 0300 Organ Transplants

DMAS Medical Support Unit will review requests for Kidney, Liver, Bone Marrow and Stem Cell, Heart, and Lung for all Medicaid members, and Pancreas, Heart and Lung, Small Bowel, and Small Bowel with Liver for Medicaid members under 21 years of age. Providers must submit requests to DMAS as soon as the provider is aware of the need for the transplant and prior to actual transplant procedure. Organ transplant services will be reviewed by DMAS within three business days of the submission. If there is insufficient information submitted on the request, the request will be pended and sent back to the provider with a time frame to respond. If the provider does not respond to the pended request for clinical information, or responds past the time frame given, the request will automatically be sent to a physician for review of all information that has been submitted and a final determination will be made. **A separate request for the inpatient hospitalization must be submitted to KEPRO within one business day of the actual inpatient hospitalization.** Note that a service authorization for the inpatient admission is not required for out-of-state (non-participating enrolled) facilities.

Application of EPSDT Criteria for members under the age of 21, are performed at a Physician Reconsideration Review level. Requests for organ transplant services can also be submitted by out-of-state physicians. Procedures may be performed out of the Commonwealth of Virginia only when the authorized transplant cannot be performed within the Commonwealth of Virginia because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.

Specific Information for Service Type 0302 Surgical Procedures

Providers must submit requests to KEPRO within 14 business days of the need for the surgical procedure and prior to rendering services. KEPRO will review completed requests and make a final determination. KEPRO will use the criteria as indicated in the March 9, 2012 DMAS Memo. As of July 1, 2012 there will be no retroactive authorization. This means that if the provider is late submitting the request, KEPRO will review the request and make a determination from the date it was received. The only exception will be member retroactive eligibility determination. The days/units that were not submitted timely will be denied and appeal rights provided.

Specific Information for Service Type 0303 Prosthetics

Provider must submit requests to KEPRO within 14 business days of the need for prosthetics and all components, and prior to rendering services. As of July 1, 2012 there will be no retroactive authorization. The only exception will be member retroactive eligibility determination. This means that if the provider is late submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied and appeal rights provided. KEPRO will review completed requests and make a final determination.

Service authorization checklists may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request in order to make a final determination for prosthetics and components. Information from the DMAS 4001 *(Physician's Certification of Need)* may be used to complete the checklist. The service authorization checklists are not mandatory in order to complete the request.

If providers do not wish to use the service authorization checklist, the provider may submit the completed DMAS 4001 *(Physician's Certification of Need)* in its entirety as an attachment to the request when it is submitted.

Since the information from the DMAS 4000 *(Prosthetic Devices Preauthorization Request Form)* has been incorporated into the review process, there is no longer a need for the provider to complete it for the clinical record. The DMAS 4001 *(Physician's Certification of Need)* is still required to be fully completed and present in the clinical record as indicted in the DMAS *Prosthetics Device Manual*, and may be reviewed on post payment or quality management review(s).

Specific Information for Service Type 0304 Medical Device, services/maintenance

Provider must submit requests to KEPRO within 14 business days of the need and prior to rendering services. As of July 1, 2012 there will be no retroactive authorization. The only exception will be member retroactive eligibility determination. This means that if the provider is late submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied and appeal rights provided. KEPRO will review completed requests and make a final determination.

Specific Information for Out-of-State Providers

Out-of-state providers (non-participating, enrolled) are held to the same service authorization processing rules as in state (participating, enrolled) providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to KEPRO or DMAS. If the provider is not enrolled with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO or DMAS, as timeliness of the request will be considered in the review process. KEPRO or DMAS will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled. Providers will not be penalized if DMAS does not process the enrollment request within 12 business days.

If KEPRO or DMAS receives confirmation of the provider's enrollment with Virginia Medicaid within 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO or DMAS does not receive confirmation of the provider's enrollment within the 12 business days, the request will be rejected, as the service authorization cannot be entered without the provider's National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request. Timeliness from the prior submission will not be considered with the re-submission.

Any provider not enrolled with Virginia Medicaid may do so by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the

toolbar at the top of the page, click on "*Provider Services*" and then "*Provider Enrollment*" in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Review Criteria to be Used

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. DMAS criteria may include CMS' Nationally Recognized Criteria (NRC). Therefore, all approvals must meet these agency criteria. All other criteria, including McKesson InterQual®, SIMplus®, or other McKesson review products, EPSDT, and physician review criteria are used for guidelines and reference purposes only.

McKesson InterQual®: KEPRO will apply McKesson InterQual®, SIMplus® criteria or other McKesson product criteria to certain services and DMAS criteria where McKesson InterQual® products do not exist.

McKesson SIMplus®: KEPRO will apply SIMplus® criteria to those procedure codes identified on the spreadsheet attached to the DMAS Memo dated March 9, 2012 and titled "Services Currently Reviewed by DMAS' Medical Support Unit Moving to KEPRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"*. These services will be reviewed retrospectively since *SIMplus*® is not designed for prospective review of surgeries or for any type of prior authorization. Its use is solely for retrospective review of surgeries. Providers must submit their request timely, within 2 business days, as KEPRO will apply timeliness to the review process. If there is additional information required KEPRO will pend the request for 20 business days, according to **Utilization Review Accreditation Commission (**URAC) standards. If the provider does not submit the additional information within the 20 business days specified, then the request will move forward in the review process and a final determination made with the information that has been submitted.

Specific Information for Physician Administered Drugs

DMAS provides coverage for the Physician Administered Drugs Zolgensma® (Onasemnogene abeparvovec-xioi), billed using the assigned Healthcare Common Procedure Coding System (HCPCS) code J3399, and Luxturna® (Voretigene neparvovec) billed using HCPCS code J3398, as a medical (not pharmaceutical) benefit, and with service authorization. Criteria used for authorization of these medications as well as authorization forms can be accessed via https://www.virginiamedicaidpharmacyservices.com (click on Service Authorizations).

Providers must fax service authorization requests for the medication to the DMAS Medical Support Unit (MSU); the MSU fax number is 804-452-5450. It will be the responsibility of the ordering physician to provide the DMAS MSU all pertinent clinical information for the service ordered, as well as the service provider (hospital billing department for outpatient or infusion center services) with a copy of the authorization letter.

In order for the DMAS MSU to complete a thorough review of the medical necessity, all requests as well as all pertinent medical information must be received 30 days prior to the administration of the medication; DMAS will not provide retroactive approval of a service request except for member retroactive eligibility determination. Once a request has been reviewed and the services approved or denied, a letter to the provider will be issued. A copy of the letter must be attached to the claim(s). The claim(s) will be reimbursed via the current DMAS EAPG payment methodology for Fee-for-Service members. Service authorization does not guarantee payment for the service.

Providers can find general information on the rate history for these and other procedure codes and associated program and claim processing information via the following link: https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/

COVERED SERVICES AND LIMITATIONS

Prosthetic Devices

A. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

B. Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law.

This service, when provided by an authorized vendor, must be medically necessary, and service authorized for the minimum applicable component necessary for the activities of daily living.

Eye prostheses are provided when eyeballs are missing regardless of the age of the member or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Service authorization is not required prior to billing, but post payment review is conducted.

Effective April 1, 2012, regardless of the dates of service, the provider will submit service authorization requests to KEPRO, DMAS' Service Authorization contractor. Requests may be submitted through direct data entry, telephone, facsimile or US mail. Specific information regarding the service authorization requirements and methods of submission are listed previously in this Appendix and may also be found on the contractor's website at https://dmas.kepro.com.

Refer to this Appendix D, page 25, for the out-of-state provider requirement and detailed information effective March 1, 2013.

Breast Reconstruction/ Prosthesis following Mastectomy and Breast Reduction

With service authorization, breast reconstruction surgery and prosthesis may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if service authorized, for all medically necessary indications. Such procedures shall be considered non-cosmetic.

Cosmetic Surgery

Cosmetic surgery is not covered when provided solely for the purpose of improving appearance. The exclusion of cosmetic surgery does not apply to congenital deformities or to deformities or to deformities due to recent injury. When surgery also restores or improves a physiological function, it is not considered cosmetic surgery.

Effective April 1, 2012, regardless of the dates of service, the provider will submit service authorization requests to KEPRO, DMAS' Service Authorization contractor. Requests may be submitted through direct data entry, telephone, facsimile or US mail. Specific information regarding the service authorization requirements and methods of submission are listed previously in this Appendix and may also be found on the contractor's website at https://dmas.kepro.com.

Elective Surgery

Elective surgery, as defined by the Virginia Medical Assistance Program, is surgery that is not medically necessary to restore or materially improve a body function. This includes surgery for conditions such as morbid obesity, virginal breast hypertrophy, and procedures that might be considered cosmetic.

Effective April 1, 2012, regardless of the dates of service, the provider must submit service authorization requests to KEPRO, DMAS' Service Authorization contractor. Requests may be submitted through direct data entry, telephone, facsimile or US mail. Specific information regarding the service authorization requirements and methods of submission are listed previously in this Appendix and may also be found on the contractor's website at https://dmas.kepro.com

Transplant Surgery

Transplant services which are covered when medically necessary and are not experimental or investigational are: kidney and corneal transplants without age limits (effective September 7, 1989); heart, lung, and liver transplants without age limits (effective July 1, 2000); coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma, breast cancer, leukemia, and myeloma. Effective November 2017, DMAS now provides coverage for stem cell transplants for members 21 and over with a diagnosis of either Aplastic Anemia, Heritable Bone Marrow Syndrome, Paroxysmal Nocturnal Hemoglobinuria, Beta Thalassemia major or Sickle Cell Disease when a member meets medically necessary criteria. Under EPSDT, any other medically necessary transplant procedures that are not experimental or investigational are limited to persons under the age of 21 (effective July 19, 1993). The treating facility and transplant staff must be recognized by Virginia Medicaid as being capable of providing high-quality care in the performance of the requested transplant.

All transplants except for corneal transplants require service authorization (including kidney, liver, heart, lung, and bone marrow/ stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational) by DMAS Medical Support.

Transplant services for kidneys require service authorization, and the patient must be considered by Virginia Medicaid as acceptable for coverage.

Submit transplant service authorization requests by fax to DMAS Medical Support at 804-452-5450.

Inpatient hospitalization related to transplantation requires service authorization at the time of admission. Cornea transplants do not require service authorization of the procedure, but inpatient hospitalization related to such transplants requires service authorization for admission. **The inpatient hospitalization services must be authorized separately from the physician's service authorization. The inpatient hospitalization is authorized by KEPRO.**

DMAS has contracted with KEPRO to conduct medical appropriateness reviews utilizing InterQual ISD-AC criteria. To request service authorization, contact KEPRO. For information regarding the service authorization submission process, refer to the "Submitting Requests for Service Authorizations" section in this Appendix D.

For all transplants, the patient must be considered acceptable for coverage and treatment.

Bone Marrow Transplants and Clarification of the Reimbursement for Transplants

Medicaid covers Bone Marrow Transplants to all eligible individuals who have a diagnosis of lymphoma or breast cancer effective for dates of services on and after July 1, 1997.

Effective November 1, 2016, regardless of the dates of service, DMAS Medical Support Unit must service authorize the transplant procedure. Hospitals must have the admission and length of stay for inpatient services approved by KEPRO.

Reimbursement for transplants is a contractual fee that covers procurement costs, all hospital costs from admission to discharge for the transplant procedure, and total physician costs for all physicians providing services during the transplant hospital stay, including radiologist, pathologist, oncologists, surgeons, anesthesiologist, etc. The contractual fee does not include pre – and post- hospitalization for the transplant procedure, nor does it include pre- transplant evaluation. To ensure that reimbursement is correctly calculated, hospitals must include all physicians' fees on the claim. Reimbursement shall be based on the contractual fee amount or the actual charges, should they be less than the contractual fee. Send the claims for the transplant procedure directly to:

Department of Medical Assistance Services

Attention: Payment Processing Unit

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Reimbursement

Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined not to be experimental or investigational is a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by Medicaid or a prospectively determined, procedure-specific percentage of usual and customary charges, or actual charges. The reimbursement covers:

- Procurement costs;
- All hospital cost from admission to discharge that the transplant procedure occurred; and
- Physician costs for all physicians providing services during the transplant hospital stay, including radiologist, pathologists, oncologists, surgeons, etc.

The reimbursement does not include pre and post – hospitalization that the transplant procedure did not occur, or pre-transplant evaluation. If the actual charges are lower than the fee, Medicaid will reimburse actual charges. Send claims directly to:

Department of Medical Assistance Services

Payment Processing Unit

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Reimbursement for approved transplant procedures that are performed out-of-state is made in the same manner as reimbursement for transplant procedures performed in Virginia. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Additionally, specific criteria issued by Medicaid concerning patient and facility selections must be followed for all transplant services.

Transplantation of the kidney is a surgical treatment whereby a diseased kidney is replaced by a healthy organ. Service authorization is required. The following patient selection criteria apply for the consideration of all approvals for the coverage and reimbursement for kidney transplantation.

1. Current medical therapy has failed, and the patient has failed to respond to appropriate conservative management;

2. The patient does not have other systemic disease including, but limited to, the following:

    a. Reversible renal conditions;
    b. Major extra-renal complication (malignancy, systemic disease, cerebral cardio-arterial disease);
    c. Active infection;
    d. Severe malnutrition; or
    e. Pancytopenia.

3. The patient is not both in an irreversible terminal state and on a life support system;

4. Adequate supervision will be provided to assure there will be strict adherence to the medical regimen which is required;

5. The kidney transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living;

6. A facility with appropriate expertise has evaluated the patient and has indicated the willingness to undertake the procedure; and

7. The patient does not have multiple uncorrectable severe major system congenital anomalies.

Failure to meet these criteria will result in the denial of the service authorization and coverage for the requested kidney transplant procedures. For a medical facility to qualify as an approved Virginia Medicaid provider for performing kidney transplants, the following conditions must be met:

1. The facility has available expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

2. The kidney transplantation program staff has extensive experience and expertise in the medical and surgical treatment of renal disease; Transplant surgeons on the staff have been trained in the kidney transplantation techniques at an institution with a well-established kidney transplantation program;

3. The transplantation program has adequate services to provide specialized psychosocial and social support for patients and families;

4. Adequate block bank support services are present and available;

5. Satisfactory arrangements exist for donor procurement services;

6. The institution is committed to a program of at least 25 kidney transplantations a year;

7. The center has a consistent, equitable, and practical protocol for the selection of patients (at a minimum, the Medicaid Patient selection Criteria must be met and adhered to);

8. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

9. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;

10. The hospital has an active, ongoing renal dialysis service;

11. The hospital has access to staff with extensive skills in tissue typing, immunological, and immunosuppressive techniques; and

12. Initial approval as a kidney transplantation center requires performance of 25 kidney transplantations within the most recent 12 months, with a one-year survival rate of at least 90%.

13. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval. Failure to meet the volume requirement following the conditional approval will result in the loss of approval.

Transplantation of the cornea is a surgical treatment whereby a diseased cornea is replaced by a healthy organ. While service authorization is not required, the following patient selection criteria apply for the consideration of all approvals for reimbursement for cornea transplantation:

1. Current medical therapy has failed and will not prevent progressive disability;

2. The patient is suffering from one of the following conditions:

    a. Post-cataract surgical decompensation,
    b. Corneal dystrophy,

c. Post-traumatic scarring,
d. Keratoconus, or
e. Aphakia Bullous Keratopathy;

3. Adequate supervision will be provided to assure there will be strict adherence by the patient to the long-term medical regimen which is required;

4. The corneal transplantation is likely to restore a range of physical and social function suited to activities of daily living;

5. The patient is not both in an irreversible terminal state and on a life support system;

6. The patient does not have untreatable cancer, bacterial, fungal, or viral infection; and

7. The patient does not have the following eye conditions:

a. Trichiasis,
b. Abnormal lid brush and/or function,
c. Tear film deficiency,
d. Raised transocular pressure,
e. Intensive inflammation, and
f. Extensive neo-vascularization.

The facility selection criteria for cornea transplantation are:

1. The facility has available expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

2. The cornea transplantation program staff has extensive experience and expertise in the medical and surgical treatment of eye disease;

3. The transplant surgeons on the staff have been trained in the cornea transplantation technique at an institution with a well-established cornea transplantation program;

4. The transplantation program has adequate services to provide social support for patients and families;

5. Satisfactory arrangements exist for donor procurement services;

6. The institution is committed to a program of eye surgery;

7. The center has a consistent, equitable, and practical protocol for the selection of patients (at a minimum, the Medicaid Patient Selection Criteria listed above must be met and adhered to);

8. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

9. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;
10. Initial approval as a cornea transplantation center requires performance of corneal transplant surgery, with a one-year graft survival rate of at least 75%. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval.

The patient selection criteria for the provision of liver, heart, allogeneic, autologous bone marrow transplantation, and any other medical necessary transplantation procedures that are determined not to be experimental or investigational are:

A. General

The following general conditions apply to these services:

1. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis;

2. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable;

3. The transplant procedure and application of the procedure in the treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and not experimental or investigational; and

4. Service authorization by Medicaid is required. The service authorization request must contain the information and documentation required by Medicaid.

The following patient selection criteria apply for the consideration of authorization, coverage, and reimbursement:

1. The patient must be under 21 years of age at the time of the surgery; and

2. The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be service authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by Medicaid of the information submitted by the transplant team or center.

a. The member's medical condition shall be reviewed by the transplant team or program according to the transplant facility's selection criteria for that procedure, and the member shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

1. Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;
2. The patient is not in an irreversible terminal state; and

3. The transplant is likely to prolong life and restore a range of physical and social function suited to the activities of daily living.

Facility selection criteria for liver, heart, allogeneic and autologous bone transplantation, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational are:

The following general conditions apply:

1. Procedures may be performed out-of-state only when the authorized transplant cannot be performed in Virginia because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.

2. Criteria applicable to transplantation services and centers in Virginia also apply to out-of-state transplant services and facilities.

To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

1. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;

2. The transplant surgeons have been trained in the specific transplant techniques at an institution with a well-established transplant program for the specific procedure;

3. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, immunological, and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. Current full membership in the United Network for Organ Sharing for the facilities where solid organ transplants are performed; Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

8. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

9. Transplant volume at the facility is consistent with maintaining quality services; and

10. The transplant center will provide adequate psychosocial and social support services for the transplant member and family.

Criteria for high-dose chemotherapy and bone marrow/ stem cell transplantation (coverage for persons over 21 years of age) are:

The following general conditions apply to these services:

1. This must be the most effective medical therapy available yielding outcomes that are at least comparable to other therapies.

2. The transplant procedure and application of the procedure in the treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective.

3. Service authorization by Medicaid is required. The service authorization request must contain the information and documentation as required by Medicaid.

The following patient selection criteria apply for the consideration of authorization for coverage and reimbursement for individuals who have been diagnosed with lymphoma or breast cancer and have been determined by the treating health care provider to have a performance status sufficient to precede with such high-dose chemotherapy and bone marrow/ stem cell transplant:

1. The patient selection criteria of the transplant center where the treatment is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedure will be service authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by Medicaid of the information submitted by the transplant team or center.

2. The member's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure, and the member shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

    a. The patient is not in an irreversible terminal state (as demonstrated in the facility's patient selection criteria), and

    b. The transplant is likely to prolong life and restore a range of physical and social function suited to the activities of daily living.

The facility selection criteria for high-dose chemotherapy and bone marrow/ stem cell transplantation for individuals diagnosed with lymphoma or breast cancer are:

A. The following conditions shall apply:
    1. Procedures may be performed out-of-state only when the authorized transplant cannot be performed in Virginia because the service is not available, or due to capacity limitations, the transplant cannot be performed in the necessary time period.

    2. Criteria applicable to transplantation services and centers in Virginia also apply to out-of-state transplant services and facilities.

B. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

    1. The transplant program staff has demonstrated expertise and experience in the medical treatment of the specific transplant procedure;

2. The transplant physicians have been trained in the specific transplant technique at an institution with a well-established transplant program for the specific procedure;

3. The facility has expertise in immunology, infectious disease, pathology, pharmacological, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, immunological, and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

8. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

9. Transplant volume at the facility is consistent with maintaining quality services; and

10. The transplant center will provide adequate psychosocial and social support services for the transplant member and family.

These services, excluding cornea transplants, require written service authorization (see Appendix A – Definitions, “Service Authorization Request”), and the patient must be considered acceptable for coverage.

Effective November 1, 2016, providers will submit transplant service authorization requests by fax to DMAS Medical Support unit. The fax number is 804-452-5450.

Surgery for Morbid Obesity

Effective April 1, 2012, regardless of the dates of service, the provider will submit service authorization requests to KEPRO, DMAS' Service Authorization contractor. Requests may be submitted through direct data entry, telephone, facsimile or US mail. Specific information regarding the service authorization requirements and methods of submission are listed previously in this Appendix and may also be found on the contractor's website at https://dmas.kepro.com.

Orthotic Services

Orthotic device services include devices that support or align extremities to prevent or correct deformities or to improve functioning, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use. These services must be ordered by a physician.

HMOs must provide medically necessary orthotic services at least to the extent covered under Medicaid guidelines any may have their own medical criteria and service authorization procedures. Practitioners may bill for supplies and equipment, beyond those routinely included in the office visit, when used in the course of treatment in the practitioner's office. These supplies include ace bandage, sling, splint, rib belt, cervical collar, lumbosacral support, etc. Use HCPCS code 99070 when billing for a specific supply item used. Orthotics, including braces, splints, and supports, are not covered for the general adult Medicaid population under the Durable Medical Equipment (DME) Program. DME and supplies may also be covered through such programs as EPSDT, some of the waiver programs under the Community-Based Care Services, and for members being discharged from an intensive (often inpatient) rehabilitation program. Additionally, the member may receive orthotics (i.e., non-custom orthotics) through his or her practitioner during an office

visit. Coverage is available for medically necessary orthotics, when recommended as part of an approved intensive rehabilitation program and when the following criteria are satisfied via adequate and verifiable documentation. Orthotics must be:

- Ordered by the physician on the DMAS-352 (CMN);
- Directly and specifically related to an active, written, and physician-approved treatment or discharge plan;
- Based upon a physician's assessment of the member's rehabilitation potential where the member's condition will improve significantly in a reasonable and predictable period of time, or must be necessary to establish an improved functional state of maintenance; and
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician, using the correct HCPCS "L" procedure codes.

Documentation of the provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under the HCPCS "L" codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the member with instructions for the proper use.

Direct all telephone inquiries regarding the service authorization status concerning DME, home health services, hospice services, outpatient psychiatric services, and rehabilitation services to the provider HELPLINE (1-804-786-6273).

Orthotic Services – EPSDT (Children Under 21 Years of Age)

Children do not have to be enrolled in Children's Specialty Services to receive orthotics. All medically necessary orthotics are covered for children under the age of 21 years. The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician using the correct HCPCS "L" procedure codes.

Service authorization is required through DMAS Service Authorization Contractor, KEPRO. Refer to the "Submitting Requests for Service Authorizations" section in this Appendix. Documentation of provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under HCPCS "L" codes to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the member with instructions for the proper use.

Maternity and Newborn Inpatient Care

Normal vaginal deliveries with a length of stay less than or equal to three days from the date of admission do not require service authorization. Cesarean section deliveries with a length of stay less than or equal to five days from the date of admission also do not require service authorization. It is important to remember that both lengths of stays are calculated from the date of admission and not the date of delivery. The Medicaid contractor, Srv Auth Contractors, must service -authorize maternity stays which do not fall within these parameters. This service authorization must be on file with Medicaid prior to billing for the stay. The hospital must obtain all service authorizations.

Newborns who are in the normal nursery with a length of stay less than or equal to five days from the infant's date of birth also do not require service authorization. Service authorization will be required for the entire newborn stay if the infant is in any other nursery setting for any part of the stay. It is important to remember that for newborns, the infant may only be in the normal nursery, and the length of stay is calculated from the date of birth and may not exceed five days. Srv Auth Contractors must service authorize newborn stays which do not fall within these parameters. This service authorization must be on file with Medicaid prior to billing for the stay.

These service authorization requirements have no impact on the mandated maternal lengths of stay under the Virginia Medicaid inpatient hospital and early discharge follow-up visit policy.

Breast Pumps for Pregnant and Postpartum Women

Coverage of breast pumps for pregnant and postpartum women enrolled in the fee-for-service Medicaid/FAMIS/FAMIS MOMS benefits is effective January 1, 2016. (Refer to DMAS Memo dated December 2015.) Please note that women enrolled in Medicaid or FAMIS MOMS for coverage of their pregnancy may lose benefits at the end of the month following the 60th day postpartum. Refer to Chapter IV of this manual for additional detail and criteria requirements.

Breast Pumps

DMAS will cover a manual or standard single user/multi-user electric breast pump as medically necessary for the initiation or continuation of breastfeeding (up to the child's first birthday). A multi-user electric hospital grade breast pump is not medically necessary when the required criteria are not met or when it is requested solely to allow for the mother's return to work or mother's or family convenience. These breast pump codes are available:

- E0602 Manual breast pump, purchase – does **not** require service authorization;
- E0603 Single user electric breast pump, purchase – requires service authorization
- E0604 Multi-user (Hospital grade) electric pump, rental – requires service authorization,
- E1399 Additional collection kit for use with the single and multi-user electric breast pumps - requires service authorization.

DME providers must submit medical justification to KEPRO when requesting service that requires Srv Auth. Refer to Chapter IV of this manual for additional information.

Non-Emergency, Outpatient MRI, CAT and PET Scans

Effective August 1, 2003, the Department of Medical Assistance Services (DMAS) implemented a mandatory service authorization process for all non-emergency, planned and scheduled outpatient, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograph (MRA), Computerized Axial Tomography (CAT), and Position Emission Tomography (PET) scans. These service authorization requirements apply for all Medicaid members enrolled in fee-for-service, as well as FAMIS members enrolled in fee-for-service, or Primary Care Case Management (PCCM) programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room.

The following information outlines the procedures for obtaining service authorization and reimbursement for these non-emergency, outpatient scans at in-state facilities only. For out-of-state facilities, refer to the section titled **Specific Information for Out-of-state Providers**

DMAS has contracted with the KEPRO to conduct medical appropriateness reviews utilizing InterQual ISX criteria, a McKesson Health Solutions, LLC product. To request service authorization, contact KEPRO. For information regarding the service authorization submission process, refer to the "Submitting Requests for Service Authorizations" section in this Appendix D.

It is the responsibility of the ordering physician or his/her representative, hospital, facility or radiologist to contact KEPRO and provide the necessary information and medical appropriateness indications for the scan being ordered.

Upon receipt of the case, a reviewer will reassess the information against InterQual® ISX (Indications for Imaging Studies and X-rays) criteria. If the case information satisfies the criteria, an approval is given for the requested diagnostic test. If the documentation submitted does not satisfy the criteria, a referral will be made to a peer reviewer for the determination.

If the patient has Medicare Part B, service authorization is not required unless Medicare has been billed and denied. Likewise, if the Medicare benefits are exhausted, the health care provider must submit a Srv Auth request for retrospective review within 30 days of the notice of denial or exhaustion by Medicare. If the patient has been determined to be eligible

for Medicaid covered services retrospectively, and his/her coverage is made retroactive to include the scanning date of service, the ordering physician or his/her representative, hospital, facility or radiologist must contact KEPRO for retrospective authorization. Prior to billing Medicaid the provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 days of the notice of Medicaid eligibility.

Also, urgent scans that are performed prior to obtaining service authorization must be retrospectively authorized. The definition of an urgent scan is when the ordering physician identifies an urgent need to have a scan performed the same day as seen by the physician. The physician sends the patient immediately to the hospital or scanning facility to have the scan performed. The ordering physician or his/her representative, hospital, facility or radiologist must contact KEPRO for retrospective authorization within one business of the scan being performed.

When contacting KEPRO to perform retrospective review, notify KEPRO that Medicare Part B has been denied, or that the patient has retroactive eligibility, or that the scan was performed on an urgent basis and provide the necessary information and medical appropriateness indications for the scan that has already been performed. Refer to this Appendix D, page 25, for the out-of-state provider requirement and detailed information effective March 1, 2013.

Outpatient Rehabilitation Services

Effective August 1, 2010 for physicians and professionals service authorization (Srv Auth) is required prior to service delivery and claims submission. Service authorization is to be obtained through KEPRO, the service authorization contractor for the Department of Medical Assistance Services (DMAS).

Effective April 1, 2012, three revenue codes are available for out-of-state general hospital providers and out-of-state rehabilitation hospital providers to use. These codes require service authorization through KEPRO. See the DMAS Memo dated March 9, 2012, titled **"**Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review, *effective April 1, 2012* and New Procedures Codes Requiring Service Authorization, *effective April 1, 2012"***.** Refer to the "Submitting Requests for Service Authorizations"

section in this Appendix for details.

Refer to the Rehabilitation Manual issued by DMAS for criteria on covered services. See Appendix D, for Srv Auth information including designated CPT or specific revenue codes to use, service limits, how to submit requests to KEPRO and other Srv Auth details.

Refer to this Appendix D, page 25, for the out-of-state provider requirement and detailed information effective March 1, 2013.

Chiropractic Services

Effective April 1, 2012, Chiropractic services are available for Medicaid members under the age of 21 and through the DMAS EPSDT program. This service cannot be authorized for Medicaid members age 21 and older. Chiropractors (Provider Type 026) are the only providers to submit these requests. DMAS Service Authorization contractor, KEPRO, will apply McKesson InterQual® to certain services and DMAS criteria where McKesson InterQual® products do not exist. If unable to approve a request, then KEPRO will apply EPSDT criteria. The Chiropractic CPT codes requiring service authorization are listed below.

Chiropractic CPT codes to submit for service authorization:

98940 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

98941 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, THREE TO FOUR REGIONS

98942 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, FIVE REGIONS

98943 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, ONE OR MORE REGION

OUT-OF-STATE PROVIDER INFORMATION

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled *"Notification of a Procedural*

Change for Out-of-state Providers Submitting Requests for Service Authorization Through KEPRO".

KEPRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Specific Information for Out-of-State Providers

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within the 12 business days,

KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

"Effective September 12, 2016, KEPRO added additional questions to the out-of-state provider questionnaire (found on the Provider Portal):

a. Question #2 - If the medical services are needed, will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel."
b. Question #5 - "In what state is the provider rendering the service and/or delivering the item physically located?"
c. Question #6 - "In what state will this service be performed?"
d. Question #7 - "Can this service be provided by a provider in the state of

   Virginia? If a provider answers "No", then additional question #7.2.1 asks: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10120 and 42 CFR 431.52.

How to Determine if Services Require Service Authorization

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/pr-fee_files.htm. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help to determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, next determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the

TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 – No PA is required

01 – Always needs a PA

02 -Only needs PA if service limits are exceeded

03- Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of “999” indicates that a service is non-covered by DMAS.

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace.

The new expansion Aid Categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL

AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following covered services:

Doctor, hospital and emergency room services including primary and specialty care
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services, including addiction and recovery treatment
Rehabilitative services, including physical, occupational, and speech language therapies
Family planning
Transportation to appointments for Medicaid approved services
Home Health
DME and supplies
Long Term Support Services (LTSS), including Nursing Facility, PACE and Home and Community Based Services, including waivers
Preventive and wellness services, including annual wellness exams, immunizations, smoking cessation and nutritional counseling
Chronic disease management
Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the inpatient and outpatient services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.

REFERENCE OF MANUALS FOR SERVICE AUTHORIZATION

Psychiatric Inpatient Services

Please refer to the “Psychiatric Manual” Service Authorization appendix.

Medical /Surgical Inpatient Services

Please refer to the “Hospital Manual” Service Authorization appendix.

Durable Medical Equipment and Supplies (DME)

Please refer to the “DME Manual” Service Authorization appendix.

Service Authorization Process for Physician Services

Please refer to the “Physician/Practitioner Manual” Service Authorization appendix.

Rehabilitation Services

Please refer to the “Rehabilitation Manual” Service Authorization appendix.

EXHIBITS (PP)

Please use this link to search for DMAS forms listed below:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch

1. DMAS-352 Certification of Medical Necessity Form
2. Service Authorization Request for Non-Covered New Drugs